UTAH
TBI Needs Assessment—Individuals with TBI

Are you receiving help filling this out?
- □ Yes
- □ No

Please provide the following demographic information:

1. Where do you live: City: _____ County: _____

2. Gender
   - □ Male
   - □ Female

3. What is your Race/Nationality?
   - □ African American
   - □ Asian
   - □ Hispanic/Latino
   - □ Pacific Islander
   - □ Native American
   - □ White
   - □ Other (Please Specify) _____

4. What is your present age: _____

5. At what age were you injured: _____

Have you had more than one TBI ____yes ____no
If, yes how many _____

6. How were you first injured?
   - □ Motorized vehicle: *Please check what type of vehicle:*
     Car □ Truck □ Motorcycle □ ATV □ Other □ _____
   - □ Bicycle
   - □ Bicycle/Auto accident
   - □ Pedestrian
   - □ Near Drowning
   - □ Fall
   - □ Assault/Abuse
   - □ Firearms/Gun Shot
   - □ Medical condition (example: stroke, infection) *describe:* _____
   - □ Sports (please identify type of sport): _____
   - □ Military
   - □ Injured another way (for example: horseback riding, swimming, etc.)
     Please describe: _____

7. What services did you received immediately following your traumatic brain injury? Please check all boxes that apply.
   - □ Emergency department care only
   - □ Inpatient hospital care
   - □ Rehabilitation (inpatient/outpatient)
   - □ Non-hospital based residential program (for example: supported living)
   - □ Nursing home
   - □ Mental Health Counseling
   - □ Other (for example: staying with family/significant other, receiving care at home)
     Please describe: _____

8. Following your injury, did anyone provide you with information or advise you about services available for individuals with traumatic brain injury?
   - □ Yes
   - □ No

   If *yes,* who provided you with information or advised you?
   - □ Doctor
   - □ Social Worker/Case Manager/Counselor
   - □ Rehabilitation Staff/Vocational Rehabilitation
   - □ Family/Friends
   - □ Brain Injury Association of Utah (BIAU)
   - □ Workers Compensation
   - □ Other *Please describe:* _____

School

9. Were you attending school at the time your injury occurred?
   - □ Yes
   - □ No

10. Were you able to attend school after your injury?
    - □ Yes
    - □ No

11. What is the highest level grade you have completed? _____

12. If you attended school after your injury, did you receive special education services?
    - □ I did not need special education services
    - □ I received and was satisfied
    - □ I received and was dissatisfied
    - □ I needed this service, but did not receive it

Employment

13. Were you working/employed when you had your injury?
    - □ Yes
    - □ No

    If *yes*, please check what type of work you did.
    - □ Professional
    - □ Manual Labor
    - □ Clerical
    - □ Management/Supervisory
    - □ Business Owner/Operator
    - □ Food Services
    - □ Other _____

14. Are you currently working?
    - □ Yes
    - □ No

    If *yes*, what type of work do you do?
    - □ Professional
    - □ Manual Labor
    - □ Clerical
    - □ Management/Supervisory
    - □ Business Owner/Operator
    - □ Food Services
    - □ Other (Sales etc.)

15. If not working, please check the reason why.
    - □ Not able to find work
    - □ Not able to work
    - □ Not able to find transportation to work
    - □ Student
    - □ Retired
    - □ Need training
    - □ Not working so that I don't loose my social security or VA benefits
    - □ Other *Please describe:* _____

Living Situation

16. Are you receiving the supports that you need, so you can live where you want to live?
    - □ Yes
    - □ No

    If *no*, please explain why: _____

Supports

17. Do you currently have the transportation you need?
    - □ Yes
    - □ No

    If *no*, please explain what the transportation problem is: _____

Treatment

18. Please review the following services and *check all the boxes that apply to you*. For example: You received physical therapy services and were satisfied and you need this service again.

Rehabilitation Services	Yes, I received this service and was satisfied	Yes, I received this service and was dissatisfied	I still need this service	I do not need service
Physical Therapy				
Cognitive Therapy (retraining your brain to improve everyday skills)				
Speech/Language Therapy				
Occupational Therapy				
Physical Therapy				
Vocational Evaluation				
Mental Health Counseling (individual and/or family)				
Assisted/Independent Living Services (residential care not requiring skilled nursing care)				
Case Management/Service Coordination				
Other Services				
Behavioral supports (learning ways to reduce or avoid unwanted behaviors)				
Alcohol or drug treatment (now or in the last 5 years)				
Job Coaching				
Employment (help finding employment)				
Dental				
Vision				
Personal Care				
Homemaking				
Parenting				
Nursing				
Recreation				
Community Skill Training (social skills, communication)				
Legal Services				
Money Management (bill paying, budgeting, etc.)				

Rehabilitation Services	Yes, I received this service and was satisfied	Yes, I received this service and was dissatisfied	I still need this service	I do not need service
Transportation				
Assistive Technology (items, equipment, or products that increase, maintain, or improve functional capabilities of individuals)				

Other services: *Please specify* (for example: respite care, tutoring, etc.):

19. *Please check the box* that best describes how your traumatic brain injury has affected your life.

	No change	Better	Worse
Marriage			
Education			
Employment			
Income			
Living Situation			
Medical Status			
Parenting			
Mental Health			
Support of fiends & family			

20. Describe any other areas of your life that have changed.

_____

21. What do YOU think needs to be done to improve statewide services and supports for individuals with TBI and their families?

_____

Thank you for your participation